

11954

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Myersville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>John N. Adkins</i>				<i>12 - 20 - 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>male</i>	<i>white</i>	<i>married</i>	<i>6-24-1877</i>	<i>78</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<i>day laborer</i>			<i>self-employed</i>		<i>Maryland</i>		<i>U. S.</i>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>John Adkins</i>				<i>Amanda Lewis</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<i>no</i>						<i>Mrs. Mary Adkins, Myersville, Md.</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
204.1 IMMEDIATE CAUSE							
(A) <i>Acute Myelogenous leukemia</i>							<i>1 mo.</i>
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>10/14</i> , 1955 to <i>12/21</i> , 1955 that I last saw the deceased alive on <i>12/21</i> , 1955, and that death occurred at <i>7:25 P.</i> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<i>Kenneth C. Benson</i>		<i>Middletown</i>		<i>12/22/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)			
<i>Burial</i>		<i>12-24-1955</i>	<i>Harmony Cemetery</i>	<i>Frederick Co., Md.</i>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Dec. 23, 1955</i>		<i>Floyd M. Bittle</i>		<i>Gladhill Co., Middletown, Md.</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 27 1955

RECEIVED

11955 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Frederick</u>
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Rural Middletown</u>	<u>30 years</u>	<u>Rural Middletown</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>00</u>		<u>1</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	OF DEATH:
<u>Sadie</u>	<u>F.</u>	<u>Alexander</u>	<u>12 8 1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>married</u>	<u>12-21-1880</u>
9. AGE last birthday		10. DATE OF BIRTH:	
<u>74 yrs.</u>		<u>12-21-1880</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Ezra Haupt</u>		<u>Lillie Doat</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>none</u>	
17. INFORMANT & ADDRESS:			
<u>Lawson C. Alexander, Middletown, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Diabetes Mellitus</u>		<u>June 1951</u>
ANTECEDENT CAUSE (S) <u>Chronic myocarditis</u>		<u>4</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 5, 1955, to Dec 5, 1955 that I last saw the deceased alive on Dec 5, 1955, and that death occurred at 10:00 PM, from the causes and on the date stated above.

SIGNATURE <u>Elizabeth Mada</u>	DATE THEREOF <u>12-11-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE REC'D BY LOCAL REGISTRAR <u>12-10-1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	24. FUNERAL DIRECTOR ADDRESS <u>Gladhill Co. Middletown, Md.</u>

BUREAU V. P.

DEC 12 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11927

CERTIFICATE OF DEATH

Reg. Dist. No. 131

11925

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>2 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Emmitsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hosp.</u>				STREET ADDRESS (If rural give location) <u>R.D. 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna Ruth BAKER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>DEC 3 1955</u>					
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 24, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Frederick Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Robert Wetzel</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie Kipe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Miss Ben Wetzel, Emmitsburg, Md. R.D. 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>10 days</u>	
ANTECEDENT CAUSE (B) <u>Chronic Pyelonephritis</u>						<u>? years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>14 NOV, 1955</u> , to <u>3 DEC, 1955</u> , that I last saw the deceased alive on <u>3 DEC, 1955</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Conley Jr.</u>				ADDRESS <u>M. D. Frederick, Maryland</u>		DATE SIGNED <u>12/3/55</u>	
23. BURIAL, CREMATION, REMOVE (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Elpis Lutheran Church</u>		LOCATION (City, town, or county) (State) <u>Emmitsburg, Frederick, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5 Dec 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hark</u>		24. FUNERAL DIRECTOR <u>L. H. Allison</u>		ADDRESS <u>Emmitsburg, Md.</u>	

BUREAU V. S.

DEC 7 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH  
11928 **CERTIFICATE OF DEATH**  
FOR MEDICAL EXAMINERS

11926

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b> COUNTY <u>Frederick</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Frederick</u> TOWN <u>Frederick</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>MD.</u> COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> OR TOWN <u>Frederick</u> STREET ADDRESS (If rural, give location) <u>10 Lincoln APT.</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Bertha Madeline Barnes</u> (First) (Middle) (Last)		<b>4. DATE OF DEATH</b> <u>Dec. 20</u> 19 <u>55</u> (Month) (Day) (Year)	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>3-24-1895</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Cleaning</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Private Homes</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Andrew Barnes</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Frances Myers</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY No.</b> <u>NONE</u>	
<b>17. INFORMANT AND ADDRESS</b> <u>Mrs. Marie Thomas - 4 South St. - Frederick</u>			
<b>18. MEDICAL CERTIFICATION</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>420.2</u> Immediate cause (a) <u>Angina pectoris</u> Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		<b>21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>	
<b>PLACE (Home, farm, factory, street, OF office bldg., etc.)</b> <u>Frederick</u>		<b>(CITY OR TOWN) (COUNTY) (STATE)</b> <u>Frederick Frederick Md</u>	
<b>TIME (Month) (Day) (Year) (Hour) OF INJURY</b> m. <input type="checkbox"/> Nt while at work <input type="checkbox"/> Nt while at work <input type="checkbox"/>		<b>INJURY OCCURRED</b> HOW DID INJURY OCCUR?	
<b>22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/>, suicide <input type="checkbox"/>, homicide <input type="checkbox"/>, undetermined <input type="checkbox"/>.</b>			
<b>SIGNATURE</b> <u>R. O. Scherman M.D. Deputy Medical Examiner</u>		<b>DATE SIGNED</b> <u>Dec 22-55</u>	
<b>23. BURIAL, CREMATION REMOVAL, (Specify)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-23-1955</u>	
<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Johns Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Frederick - Md.</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>22 Dec. 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Elizabeth S. Herb</u>	
<b>24. FUNERAL DIRECTOR</b> <u>C. E. Glime &amp; Son - Frederick - Md.</u>		<b>ADDRESS</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 27 1955

BUREAU V. S.



11929

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b> MARYLAND				STATE <b>Maryland</b> COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Crutchley Nursing Home</b>				STREET ADDRESS (If rural give location) <b>24 West South Street</b>			
3. NAME OF DECEASED: (First) <b>ANNIE</b> (Middle) <b>ELIZABETH</b> (Last) <b>BENNETT</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>December 13, 1955</b>			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widow</b>	8. DATE OF BIRTH: <b>May 25, 1872</b>	9. AGE last birthday: <b>83</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>At Home</b>		11. BIRTHPLACE (State or foreign country): <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME: <b>John S. Hartman</b>				14. MOTHER'S MAIDEN NAME: <b>Annie Elizabeth Full</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS: <b>330 East Third Street, Mrs. Annie E. Kroh, Frederick, Maryland</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Bronchopneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
ANTECEDENT CAUSE (B) <b>Cerebral artery thrombosis</b>				<b>10 months</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>260X</b>				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Diabetes mellitus</b>							
19A. DATE OF OPERATION: <b>0</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <b>Feb</b> , 1955, to <b>Dec 13</b> , 1955, that I last saw the deceased alive on <b>Dec 13</b> , 1955, and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>J. R. Scherbaum</b>				M. D. <b>Frederick, Maryland</b> DATE SIGNED <b>12/14/1955</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				DATE THEREOF <b>Dec. 17, 1955</b>			
NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>			
DATE REC'D BY LOCAL REGISTRAR <b>15 Dec. 1955</b>				REGISTRAR'S SIGNATURE <b>Elizabeth B. Heath</b>			
24. FUNERAL DIRECTOR <b>M&amp;R. Etchison &amp; Son, Frederick, Maryland</b>				ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 16 1955

RECEIVED

11930

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

11 ~~TOWN~~ Frederick

LENGTH OF STAY (in this place)

Lifetime

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00 307 West Second Street

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town)

OR ~~TOWN~~ Frederick

STREET ADDRESS (If rural give location)

307 West Second Street

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

ADDIE

RUTH

BLACKWELL

4. DATE

(Month)

(Day)

(Year)

OF

DEATH

December 26

1955

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE Last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

Female

White

Married

June 13, 1893

62

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Own home

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME:

Murray Lambert

## 14. MOTHER'S MAIDEN NAME:

Mary Elizabeth Mussetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

None

17. INFORMANT &amp; ADDRESS:

Mr. Paul Blackwell - 307 W. 2nd St., Frederick Md.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

10 days

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at

Not While

Work ☐At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1953, to Dec., 1955, that I last saw the deceased

alive on 12-20, 1955, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

Dec. 29, 1955

Mount Olivet Cemetery

Frederick,

Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

21 Dec. 1955

Elizabeth B. Hark

C. E. Cline &amp; Son - Frederick, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1955

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 45	
4. PLACE OF BIRTH New York, N.Y.		5. DATE OF BIRTH Jan 15, 1910		6. PLACE OF DEATH Boston, Mass.	
7. OCCUPATION Teacher		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN Dr. J. A. Smith		11. SIGNATURE OF REGISTRAR John Doe		12. SIGNATURE OF WITNESSES John Doe, Jane Doe	

BUREAU V. S.

DEC 28 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

11929

11931

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH— COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 Klineharts Alley		STREET ADDRESS (If rural, give location) 413 Klineharts Alley	
3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle) WILLIAM	(Last) BLANK
4. DATE OF DEATH	December 9, 1955		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 16 June 1887
9. AGE last birthday 68 yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Blank		14. MOTHER'S MAIDEN NAME Martha Hart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-0600	
17. INFORMANT AND ADDRESS Mrs. Lillie M. Blank, Frederick, Md.		413 Klineharts Alley	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1  
Immediate cause

(a)

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 200	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Home	(CITY OR TOWN) Frederick	(COUNTY) Frederick	(STATE) Md
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 12 Dec 55	NAME OF CEMETERY OR CREMATORY Rocky Springs Cem.	LOCATION (City, town, or county) (State) Frederick Co., Maryland
DATE REC'D BY LOCAL REG. 9 Dec 1955	REGISTRAR'S SIGNATURE Elizabeth B. Herb	24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. 3

DEC 12 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11956 **CERTIFICATE OF DEATH**

11930

131

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#1</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#1</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Mount Pleasant</b>				STREET ADDRESS (If rural give location) <b>Mount Pleasant</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <b>VERA GRACE CRAMER</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>December 29, 1955</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>January 15, 1890</b>		<b>9. AGE last birthday</b> <b>65</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Herman A. Buckey</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret E. Nusbaum</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. S. Clarence Cramer, Frederick R.D.#1, Md</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>199.1 IMMEDIATE CAUSE (A)</b> <b>Adeno-Carcinoma</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Year</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>metastases to Lung &amp;</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>abdomen, pancreas, stomach</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan. 1955, to Dec. 29, 1955, that I last saw the deceased alive on Dec. 29, 1955, and that death occurred at 12PM M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>B. Thomas</b>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. Frederick, Maryland</b>		<b>DATE SIGNED</b> <b>30 Dec 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Jan. 2, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Glade Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Walkersville, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>3 Dec. 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Elizabeth G. Heck</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			







1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11931

11957

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#5</b>		LENGTH OF STAY (In this place) <b>2 Weeks</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick-Rural RD#3</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Montevue</b>				STREET ADDRESS (If rural give location) <b>Yellow Springs</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <b>GEORGE</b>		(Middle) <b>WILLIAM</b>		(Last) <b>CREBBS</b>		<b>December 17, 19 55</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>7 July 1875</b>		<b>9. AGE last birthday</b> <b>80</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Day Laborer</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John B. Crebbs</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Holtzapple</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Elmer R. Crebbs, RD#3, Frederick, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422.1 IMMEDIATE CAUSE (A)</b> <b>Chronic myocarditis</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>unk.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Arterio-sclerosis</b>						<b>unk.</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Dec 4, 1955, to Dec 17, 1955, that I last saw the deceased alive on Dec 4, 1955, and that death occurred at 11:30A M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>H. F. Kline</i>				<b>ADDRESS (Street, city, town, state)</b> <b>Frederick, Maryland</b>		<b>DATE SIGNED</b> <b>19 Dec 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>20 Dec 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Pleasant Hill Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Near Yellow Springs, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Elizabeth B. Heck</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			
<b>DATE</b> <b>20 Dec. 1955</b>							



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11932

## CERTIFICATE OF DEATH

11932

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>		STREET ADDRESS (If rural give location) <b>450 West South Street</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>MEHRL COLUMBUS CRUMMITT</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>December 15, 1955</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>May 29, 1892</b>	<b>9. AGE last birthday</b> <b>63</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Railroad</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Albert Crummitt</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Creager</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>705-12-3741</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Mabel M. Crummitt, 450 West South Street, Frederick, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>154X IMMEDIATE CAUSE (A)</b> <b>Antomites</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Carcinoma of rectum</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Sigmoid - perforated</b>				<b>year +</b>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21a. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Dec 3, 1955, to Dec 15, 1955, that I last saw the deceased alive on Dec 14, 1955, and that death occurred at 3:45 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>B. Thomas</i>				<b>ADDRESS (Street, city, town, state)</b> <b>Frederick, Maryland</b>		<b>DATE SIGNED</b> <b>12/16/1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Dec. 19, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Frederick Memorial Park</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Frederick, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Elizabeth B. Heck</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			
<b>DATE</b> <b>16 Dec 1955</b>							



**INSTRUCTIONS**

**1**

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11933

11953 CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> TOWN <b>Brunswick</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>Brunswick</b> TOWN <b>Brunswick</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>516 West Potomac</b>		STREET ADDRESS (If rural give location) <b>516 West Potomac</b>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>Bessie Broome Danner</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>12 22 55</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED <b>Widowed</b>	8. DATE OF BIRTH <b>8-23-1876</b>
9. AGE last birthday <b>79</b> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.) <b>22 19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas Williams</b>		14. MOTHER'S MAIDEN NAME <b>Virginia A. Denton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT & ADDRESS <b>Doras Robertson, Brunswick, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <b>Seriously</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arteriosclerosis</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12-22-55</b> to <b>12-23-55</b> , that I last saw the deceased alive on <b>12-22-55</b> , and that death occurred at <b>11:45</b> M., from the causes and on the date stated above. SIGNATURE <b>Eugenia H. Busche</b> M.D. ADDRESS <b>Brunswick, Md.</b> DATE SIGNED <b>12-23-55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>12-26-55</b>	NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>	LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>
24. REC'D BY REGISTRAR DATE <b>1-3-56</b>	REGISTRAR'S SIGNATURE <b>Eugenia H. Busche</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C.H. Feete and Bro. Brunswick, Md.</b>	



1933 CERTIFICATE OF DEATH

Name of Deceased John Thomas Williams		Sex Male		Age 35		Date of Death Jan 5, 1933		Place of Death Home	
Cause of Death Heart Disease		Manner of Death Natural		Occupation Teacher		Residence 123 Main St, Baltimore, Md.		Burial Place Greenwood Cemetery	
Physician's Signature <i>John A. Williams</i>		Medical Certification The above is a true and correct statement of the facts as stated on the certificate of death.		Signature of Registrar <i>John A. Williams</i>		Signature of Coroner <i>John A. Williams</i>		Signature of Minister <i>John A. Williams</i>	
Signature of Minister <i>John A. Williams</i>		Signature of Coroner <i>John A. Williams</i>		Signature of Registrar <i>John A. Williams</i>		Signature of Physician <i>John A. Williams</i>		Signature of Burial Place <i>John A. Williams</i>	

RECEIVED  
JAN 5 1933  
BUREAU V. E. 1-3-33

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT VALID UNLESS IT IS SIGNED BY THE REGISTRAR OF DEATHS, THE CORONER, THE MINISTER OF THE GOSPEL, AND THE PHYSICIAN WHO ATTENDED THE DECEASED. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE OF DEATH AND TO FILE IT IN THE OFFICE OF THE REGISTRAR OF DEATHS. IT IS THE DUTY OF THE CORONER TO SIGN THIS CERTIFICATE OF DEATH AND TO FILE IT IN THE OFFICE OF THE CORONER. IT IS THE DUTY OF THE MINISTER OF THE GOSPEL TO SIGN THIS CERTIFICATE OF DEATH AND TO FILE IT IN THE OFFICE OF THE MINISTER OF THE GOSPEL. IT IS THE DUTY OF THE PHYSICIAN WHO ATTENDED THE DECEASED TO SIGN THIS CERTIFICATE OF DEATH AND TO FILE IT IN THE OFFICE OF THE PHYSICIAN WHO ATTENDED THE DECEASED.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11934

11958 **CERTIFICATE OF DEATH**

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X TOWN Frederick-Rural</u>		LENGTH OF STAY (in this place) <u>14 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Frederick County Chronic Hospital</u>		STREET ADDRESS (If rural give location) <u>616 North Market Street</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>RESTA LEVI DELAUTER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 31, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>August 22, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Delauter</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Hoover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-6298</u>		17. INFORMANT & ADDRESS <u>Mrs. Alford F. Brashear, 53 Taney Apts. Frederick, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>2 yrs +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept 22, 1955</u> , to <u>Dec 31, 1955</u> , that I last saw the deceased alive on <u>Dec 31, 1955</u> , and that death occurred at <u>11:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>B. Thomas</u>		M. D. <u>Frederick, Maryland</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/2/1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR <u>3 Jan. 1956</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

## 1955 CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED'S NAME - LAST, FIRST, MIDDLE

2. PLACE OF BIRTH

3. SEX - ☐ MALE ☐ FEMALE

4. RACE

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF WITNESS

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100. SIGNATURE OF WITNESS

101. SIGNATURE OF WITNESS

BUREAU V. S.

JAN 4 1956

RECEIVED

NOTIFICATION

THIS IS TO CERTIFY THAT THE ABOVE NAMED DECEASED HAS BEEN DECEASED AND THAT THE CAUSE OF DEATH IS AS STATED ABOVE. THIS CERTIFICATE IS VALID FOR ALL PURPOSES AND ALL GOVERNMENT AGENCIES OF THE UNITED STATES AND ALL FOREIGN COUNTRIES SHALL BE BOUND BY THE SAME. THIS CERTIFICATE IS VALID FOR ALL PURPOSES AND ALL GOVERNMENT AGENCIES OF THE UNITED STATES AND ALL FOREIGN COUNTRIES SHALL BE BOUND BY THE SAME.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11933 CERTIFICATE OF DEATH

11935

Reg. Dist. No. 13.1

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY OR TOWN <u>Frederick</u>		LENGTH OF STAY (in this place) <u>4 Days</u>		CITY OR TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>7 West All Saints Street</u>			
3. NAME OF DECEASED (Type or Print) <u>YVONNE</u> (First) <u>Disney</u> (Middle) <u>Disney</u> (Last)				4. DATE OF DEATH (Month) <u>December</u> (Day) <u>26</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 22, 1955</u>	9. AGE last birthday <u>4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Paul Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Mae Disney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Dorothy Disney</u> <u>7-W. ALL SAINTS ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
773.5 IMMEDIATE CAUSE (A) <u>Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>3:45 P.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-22, 1955</u> , to <u>12-26, 1955</u> , that I last saw the deceased alive on <u>12-26, 1955</u> , and that death occurred at <u>3:45 P.</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Frank J. Hearn</u>				ADDRESS (Street, city, town, state) <u>220 N. Market St.</u>		DATE SIGNED <u>12-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>BARTONSVILLE</u>		LOCATION (City, town, or county) (State) <u>BARTONSVILLE-Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. E. Hicks III</u>		ADDRESS <u>Fred. Md.</u>	
DATE <u>28 Dec 1955</u>							

10V5204251N

DEPARTMENT OF HEALTH

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THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO SHALL TRANSMIT IT TO THE DEPARTMENT OF HEALTH. IT IS TO BE FURNISHED TO THE FUNERAL HOME OR TO THE PERSON IN CHARGE OF THE BURIAL. IT IS TO BE FURNISHED TO THE PERSON IN CHARGE OF THE BURIAL. IT IS TO BE FURNISHED TO THE PERSON IN CHARGE OF THE BURIAL.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH: JAN 2 1936

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

IMMEDIATE CAUSE: [illegible]

INTERMEDIATE CAUSE: [illegible]

PREEXISTING DISEASE: [illegible]

MODE OF DEATH: [illegible]

PERIOD OF ILLNESS: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

RELIGION: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RESIDENCE: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF ENTRY INTO STATE: [illegible]

DATE OF ENTRY INTO COUNTRY: [illegible]

DATE OF ENTRY INTO CITY: [illegible]

DATE OF ENTRY INTO DISTRICT: [illegible]

DATE OF ENTRY INTO WARD: [illegible]

DATE OF ENTRY INTO BLOCK: [illegible]

DATE OF ENTRY INTO STREET: [illegible]

DATE OF ENTRY INTO HOUSE: [illegible]

DATE OF ENTRY INTO ROOM: [illegible]

DATE OF ENTRY INTO BED: [illegible]

DATE OF ENTRY INTO CHAIR: [illegible]

DATE OF ENTRY INTO TABLE: [illegible]

DATE OF ENTRY INTO CUPBOARD: [illegible]

DATE OF ENTRY INTO DOOR: [illegible]

DATE OF ENTRY INTO WINDOW: [illegible]

DATE OF ENTRY INTO FLOOR: [illegible]

DATE OF ENTRY INTO WALL: [illegible]

DATE OF ENTRY INTO CEILING: [illegible]

DATE OF ENTRY INTO BASEMENT: [illegible]

DATE OF ENTRY INTO ATTIC: [illegible]

DATE OF ENTRY INTO GARAGE: [illegible]

DATE OF ENTRY INTO PORCH: [illegible]

DATE OF ENTRY INTO PATIO: [illegible]

DATE OF ENTRY INTO DRIVE: [illegible]

DATE OF ENTRY INTO YARD: [illegible]

DATE OF ENTRY INTO GARDEN: [illegible]

DATE OF ENTRY INTO FIELD: [illegible]

DATE OF ENTRY INTO WOODS: [illegible]

DATE OF ENTRY INTO MOUNTAINS: [illegible]

DATE OF ENTRY INTO RIVERS: [illegible]

DATE OF ENTRY INTO LAKES: [illegible]

DATE OF ENTRY INTO OCEANS: [illegible]

DATE OF ENTRY INTO SPACE: [illegible]

DATE OF ENTRY INTO TIME: [illegible]

DATE OF ENTRY INTO MATTER: [illegible]

DATE OF ENTRY INTO ENERGY: [illegible]

DATE OF ENTRY INTO INFORMATION: [illegible]

DATE OF ENTRY INTO KNOWLEDGE: [illegible]

DATE OF ENTRY INTO WISDOM: [illegible]

DATE OF ENTRY INTO FAITH: [illegible]

DATE OF ENTRY INTO HOPE: [illegible]

DATE OF ENTRY INTO CHARITY: [illegible]

DATE OF ENTRY INTO LOVE: [illegible]

DATE OF ENTRY INTO PEACE: [illegible]

DATE OF ENTRY INTO JOY: [illegible]

DATE OF ENTRY INTO HAPPINESS: [illegible]

DATE OF ENTRY INTO GLORY: [illegible]

DATE OF ENTRY INTO LIFE: [illegible]

DATE OF ENTRY INTO DEATH: [illegible]

DATE OF ENTRY INTO RESURRECTION: [illegible]

DATE OF ENTRY INTO JUDGMENT: [illegible]

DATE OF ENTRY INTO HEAVEN: [illegible]

DATE OF ENTRY INTO HELL: [illegible]

DATE OF ENTRY INTO PARADISE: [illegible]

DATE OF ENTRY INTO PURGATORY: [illegible]

DATE OF ENTRY INTO LIMBO: [illegible]

DATE OF ENTRY INTO LIMBOS: [illegible]

DATE OF ENTRY INTO LIMBOS: [illegible]

DATE OF ENTRY INTO LIMBOS: [illegible]

DATE OF ENTRY INTO LIMBOS: [illegible]

BUREAU V. S.

JAN 2 1936

RECEIVED

11959 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Urbana		65 yrs.		TOWN Urbana -- 7 miles S. of Frederick		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
Mary Rosalia Dudderar				Dec. 28 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Widowed		Jan. 4-1868	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
87 yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife				Own home		Maryland	
12. CITIZEN OF WHAT COUNTRY?				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John C. Kidd				Ann Howard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
3 No				None		Mrs. Dorothy D. Hull (daughter) Urbana-Md.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.0 Congestive failure + uremia						10 days	
Immediate cause DUE TO							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO						6 yrs.	
Arterio-sclerotic heart dis.							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						2 wks	
Auricular fibrillation							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At Work		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 51, to 28 Dec, 19 55, that I last saw the deceased alive on 27 Dec, 19 55, and that death occurred at 4 A.M., from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Charles H. Conley, Jr. M.D.				Frederick, Maryland		12/29/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12-30-1955		Mt. Olivet Cemetery		Frederick- Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Dec. 30-1955		Elizabeth B. Heck		C. E. Cline & Son		Frederick- Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE ABOVE INFORMATION WAS OBTAINED FROM THE FOLLOWING SOURCES:

JAN 2 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11960

## CERTIFICATE OF DEATH

11937

Reg. Dist. No. 131

Item 9, Film G190 12-23-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
Frederick - Rural				Frederick Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Montevue County Home				Montevue County Home			
3. NAME OF DECEASED: (First) JOSEPH		(Middle) -----		(Last) ELDRIDGE		4. DATE OF DEATH: (Month) December (Day) 19 (Year) 55	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Unknown	9. AGE last birthday: Approx. 80 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Unknown		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Mat Burras (Eldridge)				14. MOTHER'S MAIDEN NAME: Maggie Hill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unknown		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Montevue County Home - Frederick, Maryland			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset and Death	
Immediate cause (a) Chronic myocarditis						3410	
Antecedent causes (s) (b) Chronic nephritis						3410	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Arterio Sclerosis						3415	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 19, 1953, to Dec 19, 1953, that I last saw the deceased alive on Dec 19, 1953, and that death occurred at 3:00 P.M., from the causes and on the date stated above.							
SIGNATURE H. F. Kline M.D.		(Degree or title)		ADDRESS Frederick Md		DATE SIGNED Dec 20 1953	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		Dec. 20, 1955		Anatomical Board		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
20 Dec. 1953		Elizabeth G. Heck		C. E. Cline & Son - Frederick, Maryland			

RECEIVED



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11961 CERTIFICATE OF DEATH

11938

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (if outside corporate limits, write RURAL and give nearest town) X TOWN Frederick-Rural RD#3		LENGTH OF STAY (in this place) Years		CITY (if outside corporate limits, write RURAL and give nearest town) TOWN Frederick-Rural RD#3		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Near Yellow Springs				STREET ADDRESS (if rural give location) Near Yellow Springs			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) URIAH		(Middle) VERNON		(Last) FEAGA		December 17, 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 20 July 1870	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Julia A. R. McLane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS 408 Culler Ave., Russell S. Feaga, Frederick, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH 12 hours			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				5 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 10, 1953</u> , to <u>Dec 17, 1955</u> , that I last saw the deceased alive on <u>Jan 15, 1955</u> , and that death occurred at <u>9:45A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>B. B. Thomas</u> M.D. Frederick, Maryland				DATE SIGNED 19 Dec 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 20 Dec 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
24. REC'D BY REGISTRAR DATE 19-Dec-1955		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			

# 1951 CERTIFICATE OF DEATH

1. Name of deceased: *John J. Smith*

2. Sex: *Male* Date of birth: *10/15/1895*

3. Usual residence: *1234 Main St., Baltimore, Md.*

4. Date of death: *11/10/1951* Time of death: *10:30 AM*

5. Place of death: *Home*

6. Cause of death: *Myocardial Infarction*

7. Immediate cause of death: *Coronary artery disease*

8. Underlying cause of death: *Arteriosclerosis*

9. Contributing causes: *Hypertension, Diabetes Mellitus*

10. Manner of death: *Natural*

11. Signature of physician: *Dr. J. H. Smith*

12. Signature of registrar: *John J. Smith*

13. Date of registration: *11/15/1951*

14. Place of registration: *Baltimore, Md.*

15. Name of registrar: *John J. Smith*

16. Name of physician: *Dr. J. H. Smith*

17. Name of hospital: *St. Mary's Hospital*

18. Name of doctor: *Dr. J. H. Smith*

19. Name of nurse: *Miss J. H. Smith*

20. Name of attendant: *Mr. J. H. Smith*

21. Name of undertaker: *Mr. J. H. Smith*

22. Name of funeral home: *Mr. J. H. Smith*

23. Name of cemetery: *St. Mary's Cemetery*

24. Name of burial place: *St. Mary's Cemetery*

25. Name of interment: *St. Mary's Cemetery*

26. Name of cremation: *St. Mary's Cemetery*

27. Name of disposition: *St. Mary's Cemetery*

28. Name of final disposition: *St. Mary's Cemetery*

29. Name of final disposition: *St. Mary's Cemetery*

30. Name of final disposition: *St. Mary's Cemetery*

31. Name of final disposition: *St. Mary's Cemetery*

32. Name of final disposition: *St. Mary's Cemetery*

33. Name of final disposition: *St. Mary's Cemetery*

34. Name of final disposition: *St. Mary's Cemetery*

BUREAU V. S.

DEC 31 1955

RECEIVED

*John J. Smith*



11939

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11934 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN Frederick</u>	LENGTH OF STAY (in this place) <u>5 Minutes</u>	If outside corporate limits, write RURAL and give nearest town <u>TOWN Lewistown Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Memorial</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Zacharias Ursinius Fitor</u>		OF DEATH: <u>Dec. 14</u> 19 <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Aug 24 - 1876</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>79</u> yrs.		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Farmer</u>		<u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Thurmont Fredk Co Md</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Martin David Fitor</u>		<u>Mary Heaser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>none</u>	
17. INFORMANT & ADDRESS:			
<u>George M. Fitor, Thurmont, Md R.D.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.0</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Acute Pulmonary Edema</u>			<u>2 hrs.</u>
DUE TO			
(B) <u>Arteriosclerotic Heart Disease</u>			<u>2 yrs.</u>
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/14</u> , 19 <u>55</u> , to <u>12/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>55</u> , and that death occurred at <u>10:45</u> PM, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Henry V. Chase M.D.</u>		<u>12/14/55</u>	
M.D. <u>H. V. Chase</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>Dec. 17, 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Blue Ridge Cem</u>		<u>Thurmont Md</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>16 Dec. 1955</u>		ADDRESS	
REGISTRAR'S SIGNATURE			
<u>Elizabeth B. Hark</u>		<u>M.L. Creager Thurmont MD</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 19 1955

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11940

Item 18 Film G19Q 12-23-55 ams

1-3-55

11935

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>				STREET ADDRESS (If rural give location) <b>8 West Sixth Street</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>NETTIE SYRENA FISHER</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>December 16, 19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>1 July 1896</b>	<b>9. AGE last birthday</b> <b>59</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House-work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Jeremiah Mahammitt</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Carrie Jackson</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>8 W. 6th St., Harry W. Fisher, Frederick, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>019.2 IMMEDIATE CAUSE (A)</b> <b>PORTAL CIRRHOSIS OF LIVER</b>						<b>YRS.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>CHRONIC ALCOHOLISM</b>						<b>7 YRS.</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Miliary Tuberculosis</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>xxxxxxxxxxxxxxxxxxxx</b>							
<b>19a. DATE OF OPERATION</b> <b>22</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <b>M.</b>		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1 Nov 1955, to 16 Dec 1955, that I last saw the deceased alive on 16 Dec 1955, and that death occurred at 6:15 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Thomas E. Stone</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>4 W 3rd St</b>			
<b>DATE SIGNED</b> <b>16 Dec 55</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>19 Dec 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Silver Hill Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Frederick County Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>19 Dec. 1955</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Elizabeth L. Heib</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			

BUREAU V. S.

DEC 21 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11941

## 11962 CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Libertytown</u>		Years		TOWN <u>Libertytown</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>				STREET ADDRESS (If rural give location) <u>Main Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Carlton</u>		(Middle) <u>Elsworth</u>		(Last) <u>Fogle</u>		(Month) <u>Dec.</u> (Day) <u>4</u> (Year) <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>May 12, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Fogle</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Long</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-05-6268</u>		17. INFORMANT & ADDRESS <u>Benjamin Fogle, Libertytown Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						1 minute	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic CVD</u>						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1883</u> , 19 <u>54</u> , to <u>4 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3 Dec</u> , 19 <u>56</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James S. Stoner, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Waltherville, Md</u> DATE SIGNED <u>5 Dec 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 7, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Linganore</u>		LOCATION (City, town, or county) (State) <u>Unionville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heik</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler &amp; Sons</u>		ADDRESS <u>Libertytown Md</u>	
DATE <u>7 Dec. 1955</u>							



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THIS IS A SUMMARY OF THE INFORMATION RECEIVED FROM THE BUREAU OF VITAL STATISTICS OF THE STATE OF MARYLAND, AND IS NOT A SUBSTITUTE FOR THE ORIGINAL RECORDS. IT IS INTENDED TO BE USED FOR GENERAL INFORMATION ONLY. FOR MORE DETAILED INFORMATION, PLEASE REFER TO THE ORIGINAL RECORDS.

# STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. No. 100

1. NAME OF DECEASED (Print or Write)

2. SEX ( ) Male ( ) Female

3. DATE OF BIRTH ( ) ( ) ( )

4. PLACE OF BIRTH ( ) ( ) ( )

5. OCCUPATION ( ) ( ) ( )

6. CAUSE OF DEATH ( ) ( ) ( )

7. PLACE OF DEATH ( ) ( ) ( )

8. TIME OF DEATH ( ) ( ) ( )

9. SIGNATURE OF PHYSICIAN ( ) ( ) ( )

10. SIGNATURE OF REGISTRAR ( ) ( ) ( )

11. SIGNATURE OF WITNESS ( ) ( ) ( )

12. SIGNATURE OF DECEASED ( ) ( ) ( )

13. SIGNATURE OF NEXT OF KIN ( ) ( ) ( )

14. SIGNATURE OF CLERGYMAN ( ) ( ) ( )

15. SIGNATURE OF CHURCH OFFICER ( ) ( ) ( )

16. SIGNATURE OF BURIAL OFFICER ( ) ( ) ( )

17. SIGNATURE OF INTERMENT OFFICER ( ) ( ) ( )

18. SIGNATURE OF FUNERAL HOME ( ) ( ) ( )

19. SIGNATURE OF CEMETERY ( ) ( ) ( )

20. SIGNATURE OF OTHER ( ) ( ) ( )

21. SIGNATURE OF OTHER ( ) ( ) ( )

22. SIGNATURE OF OTHER ( ) ( ) ( )

23. SIGNATURE OF OTHER ( ) ( ) ( )

24. SIGNATURE OF OTHER ( ) ( ) ( )

25. SIGNATURE OF OTHER ( ) ( ) ( )

BUREAU V. S.

DEC 9 1955

RECEIVED

11936

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL or give nearest town) <u>11 TOWN FREDERICK</u>		LENGTH OF STAY (in this place) <u>26 da</u>		OR TOWN <u>THURMONT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 FREDERICK MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>WEST MAIN STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARTIN E. FOREMAN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>DECEMBER 7 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>JANUARY 14, 1864</u>	9. AGE last birthday: <u>91</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Business</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Foreman</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Sefton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>None</u>		17. INFORMANT & ADDRESS: <u>William Foreman Thurmont, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Anteriosclerotic Heart Disease</u>						15 yrs +	
(B) _____							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Benign prostatic hypertrophy, cellulitis, right shoulder</u>						5 yrs. +, 6 days.	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-11</u> , 1955 to <u>12-7</u> , 1955 that I last saw the deceased alive on <u>12-7</u> , 1955, and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry V. Chase</u>		ADDRESS <u>M. D. 4 E. Church St</u>		DATE SIGNED <u>12/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>U.B. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Thurmont, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Dec 9-1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth L. Heck</u>		24. FUNERAL DIRECTOR <u>M.L. Creager and Son</u>		ADDRESS <u>Thurmont, Md.</u>	

MARGIN RESERVED FOR FUNDING

BUREAU V. S.

DEC 12 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11937

## CERTIFICATE OF DEATH

11943

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Several Years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>		STREET ADDRESS (If rural give location) <b>65 South Market Street</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>ESTELLA MARY JANE FREED</b> (Also Known As <b>Stella M. Freed</b> )				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>December 17, 1955</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Divorced</b>	<b>8. DATE OF BIRTH</b> <b>10 April 1890</b>	<b>9. AGE last birthday</b> <b>65</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House-work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Edward S. Earnest</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Clara E. Poole</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>65 S. Market St., Frank E. Harley, Frederick, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>442X IMMEDIATE CAUSE (A)</b> <b>Chronic Myocarditis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs.</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Chronic interstitial nephritis</b>				<b>5 yrs.</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <b>Arteriosclerosis</b>				<b>5 yrs.</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>1950</b> , <b>to Dec 17, 1955</b> , <b>that I last saw the deceased alive on</b> <b>Dec 17, 1955</b> , <b>and that death occurred at</b> <b>4 P.</b> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>H. F. Kline</b>				<b>DATE SIGNED</b> <b>19 Dec 1955</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>21 Dec 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Beaver Dam Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b> <b>Elizabeth B. Hech</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	
<b>DATE</b> <b>20 Dec, 1955</b>				<b>ADDRESS</b> <b>19 Dec 1955</b>			

# CERTIFICATE OF DEATH

1955

REG. NO. 10-10-10

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Place of Death

8. Cause of Death

9. Manner of Death

10. Signature of Physician

11. Signature of Registrar

12. Signature of Coroner

13. Signature of Medical Examiner

14. Signature of Funeral Home

15. Signature of Burial Place

16. Signature of Cemetery

17. Signature of Interment

18. Signature of Burial

19. Signature of Burial

20. Signature of Burial

21. Signature of Burial

22. Signature of Burial

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BUREAU V. S.

DEC 21 1955

RECEIVED

RECEIVED

RECEIVED

11963

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write and give nearest town)		RURAL		CITY (If outside corporate limits, write and give nearest town)		RURAL	
TOWN <i>Middletown</i>		LENGTH OF STAY (in this place) <i>10 years</i>		TOWN <i>Middletown</i>		TOWN <i>Middletown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Sarah E. Gaver</i>				OF DEATH: <i>12 18 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>white</i>	<i>widow</i>	<i>11-1-1882</i>	<i>73</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<i>housewife</i>				<i>own home</i>		<i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
<i>U.S.</i>				<i>Henry L. Brandenburg</i>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<i>Louisa C. Grassnick</i>				<i>none</i>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS:			
<i>none</i>				<i>Everett H. Gane, Middletown, Md.</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>						<i>suddenly</i>	
ANTECEDENT CAUSE (B) <i>Hypertension + Arterio-sclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>(Enlarged heart.)</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Cerebral Hemorrhage aug 1955</i>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<i>0</i>				<i>—</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 15, 1955</i> to <i>Dec 18, 1955</i> that I last saw the deceased alive on <i>Dec 16, 1955</i> , and that death occurred at <i>7:10 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J.E. Harp</i>		M. D. <i>Middletown</i>		DATE SIGNED <i>12-19-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12-20-1955</i>		<i>Lutheran Cemetery</i>		<i>Middletown, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>Dec 20, 1955</i>		<i>Elizabeth G. Heck</i>		<i>Blackhill Co.</i>		<i>Middletown, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 22 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11964

CERTIFICATE OF DEATH

Reg. Dist. No.

11245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WALKERSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WALKERSVILLE</u>	
LENGTH OF STAY (in this place) <u>85 yrs</u>		STREET ADDRESS (If rural give location) <u>Frederick St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES FRANKLIN GEISSINGER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec</u> <u>4</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug 13 1868</u>
9. AGE last birthday: <u>87</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country): <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Jacob Geissinger</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Filler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Minnie R. Geissinger, Walkersville, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>422.1</u>		<u>4 years</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>10 years</u>	
(A) DUE TO <u>Congestive myocardial failure</u>			
(B) DUE TO <u>Arteriosclerotic CVD</u>			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Inanition</u>		<u>6 months</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 Nov.</u> , 19 <u>48</u> , to <u>4 Dec.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4 Dec.</u> , 19 <u>55</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>James S. Stover</u>		DATE SIGNED <u>12/5/55</u>	
M. D. <u>Walkersville Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/7/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) <u>Frederick, Md.</u>	
24. FUNERAL DIRECTOR <u>J. C. Barton</u>		ADDRESS <u>Walkersville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hech</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11938

## CERTIFICATE OF DEATH

11946

Reg. Dist. No. 131

Item 9, Film G190 1-3-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Town Frederick</i>		LENGTH OF STAY (in this place) <i>3 days</i>		If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Union Bridge 067-2</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>Main St.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Florence M Gilbert</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>December 14 1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>W</i>	8. DATE OF BIRTH: <i>Dec 10 - 1878</i>		9. AGE last birthday: <i>77 1/4</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY: <i>USA</i>				13. FATHER'S NAME: <i>John J Glingan</i>			
14. MOTHER'S MAIDEN NAME: <i>Mary Whitmer</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>none</i>			
16. SOCIAL SECURITY NO.: <i>none</i>				17. INFORMANT & ADDRESS: <i>Earl Myers - Taneytown Md</i>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Small intestinal obstruction due to</i>							<i>3 days</i>
ANTECEDENT CAUSE (B) <i>gall stone</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>13 December '55</i>				19B. MAJOR FINDINGS OF OPERATION: <i>intestinal obstruction due to gall stone. carcinoma of colon</i>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11 Dec</i> , 19 <i>55</i> , to <i>14 Dec</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>15 Dec</i> , 19 <i>55</i> , and that death occurred at <i>8 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Robert H. P. P. P. M.D.</i>				ADDRESS <i>Frederick, Md.</i>		DATE SIGNED <i>14 Dec '55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>12/16/55</i>		NAME OF CEMETERY OR CREMATORY <i>Lutheran</i>	
LOCATION (City, town, or county) (State) <i>Uniontown.</i>				24. FUNERAL DIRECTOR <i>W. H. Hartley &amp; Sons, Union Bridge</i>		ADDRESS	
DATE REC'D. BY LOCAL REGISTRAR <i>Dec 15-1955</i>				REGISTRAR'S SIGNATURE <i>Edgall L. H. H.</i>			

BUREAU V. S.

DEC 21 1955

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MARYLAND STATE DEPARTMENT OF HEALTH  
11939 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

11947

Reg. Dist. No. 13.1

1. PLACE OF DEATH - COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>615 East St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Alice Margaret Giles</u>	4. DATE OF DEATH <u>12 17 1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>9-3-1899</u>
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William C. Monroe</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Lucy Mangum, Washington D.C.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>Fractured skull</u> Antecedent cause(s) (b) <u>None</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>	INTERVAL BETWEEN ONSET AND DEATH <u>None</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION <u>12-17-55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Ante-hit a culvert on highway</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input checked="" type="checkbox"/>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	(CITY OR TOWN) <u>Brunswick</u> (COUNTY) <u>Frederick</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) <u>12 17 55</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Ante-hit a culvert on highway</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>B. Thomas M.D. Deputy Medical Examiner</u>	ADDRESS <u>Frederick Md.</u>	DATE SIGNED <u>Dec 17-55</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12-20-55</u>	NAME OF CEMETERY OR CREMATORY <u>Mountain</u>
LOCATION (City, town, or county) <u>Brunswick Md.</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>20 Dec. 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>	24. FUNERAL DIRECTOR <u>C. H. Teets, Brunswick Md.</u>
		ADDRESS <u>Brunswick Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 22 1955

BUREAU V. S.

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11965

## CERTIFICATE OF DEATH

11948

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>TOWN</u> <u>Frederick-Rural-R.D.#3</u>		LENGTH OF STAY (in this place) <u>Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>Frederick-Rural-R.D.#3</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Three Pines Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Yellow Springs</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>CARRIE</u> <u>MAY</u> <u>HAHN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 26,</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 8, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Herman Buckey</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Nusbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Maurice N. Hahn, Frederick, R.D.#3, Md.</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage, due to</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterial hypertension</u>						<u>10+ years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerosis</u>						<u>10+ years.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>A.S. heart disease w/auricular Fibrillation</u>						<u>1949</u>	
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>			21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Apr</u> , 19 <u>46</u> , to <u>26 DEC</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>14 DEC</u> , 19 <u>55</u> , and that death occurred at <u>2:50 PM</u> , from the causes end on the date stated above.							
SIGNATURE <u>Charles H. Corley, Jr.</u>				ADDRESS (Street, city, town, state) <u>Frederick, Maryland</u>			
DATE <u>12/28/1955</u>				DATE SIGNED <u>12/28/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR <u>28 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heik</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

11949

11965

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 13.1

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD - Frederick</u> COUNTY	
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Centerville</u>		<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Centerville Frederick RD #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.I.</u>		STREET ADDRESS (If rural, give location) <u>Frederick RD #1</u>	
3. NAME OF DECEASED (Type or Print) <u>Edna Mae Hallman</u>		4. DATE OF DEATH <u>December 28</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Oct 1 - 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>70</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>MURIEL S. SHADEN Centerville</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Cerebral Thrombosis</u>			<u>None</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterio Sclerosis</u>			<u>2 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>B. Thomas M.D. Deputy Medical Examiner</u>		DATE SIGNED <u>Dec. 28 - 55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>Ebernezer</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>30 Dec - 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>Charles E. Hicks III Fred. Md.</u>	

RECEIVED

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BUREAU V. S.

11950

## MARYLAND STATE DEPARTMENT OF HEALTH

## 11967 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH: COUNTY <u>Frederick</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural</u> TOWN <u>Frederick County</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Chronic Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u> OR TOWN <u>06X</u> STREET ADDRESS (If rural, give location) <u>06X</u>	
3. NAME OF DECEASED (Type or Print) <u>Carric</u> (First) <u>E</u> (Middle) <u>Harbough</u> (Last)	4. DATE OF DEATH <u>Dec.</u> <u>1st</u> 19 <u>55</u> (Month) (Day) (Year)	5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11/11/1960</u>	9. AGE last birthday <u>95</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public School Teacher</u>
11. BIRTHPLACE (State or foreign country) <u>Woodsboro, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	13. FATHER'S NAME <u>Samuel Harbough</u>	14. MOTHER'S MAIDEN NAME <u>Mary Anders</u>
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT AND ADDRESS <u>Mervyn C. Fuss Taneytown Maryland</u>	18. MEDICAL CERTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>420.0 Intensive Chronic Heart Disease</u>			<u>6mo.</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Coronary Heart Failure</u>			
(c) <u>Arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Son-Lity</u>			
19a. DATE OF OPERATION <u>7/1</u>	19b. MAJOR FINDINGS OF OPERATION <u>7/1</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OR office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Nt while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>A.A. Pearce M.D.</u>		DATE SIGNED <u>Frederick Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12/4/55</u>	NAME OF CEMETERY OR CREMATORY <u>Middleburg Cemetery</u>	LOCATION (City, town, or county) (State) <u>Middleburg Maryland</u>
DATE REC'D BY LOCAL REG. <u>1 Dec. 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	24. FUNERAL DIRECTOR <u>C. C. Fless &amp; Son Taneytown, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 5 1955

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11951

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11940

## CERTIFICATE OF DEATH

Reg. Dist. No. 13 |

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>11 TOWN Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Airy</u> <u>06X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Memorial</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lottie E. Harrison</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>12</u> <u>11</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>8-29-1867</u>
9. AGE last birthday <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Benjamin Hood</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (if Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Albert Harrison, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Lobar Pneumonia, right lower and middle lobes</u>			<u>4-5 days</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, generalized</u>			<u>? years</u>
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/10</u> , 19 <u>55</u> , to <u>12/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/11</u> , 19 <u>55</u> , and that death occurred at <u>12:30</u> P M, from the causes and on the date stated above.			
SIGNATURE <u>Henry V. Chase</u>		ADDRESS <u>M. D. 4 E. Church St. Fred.</u> DATE SIGNED <u>12/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-14-1955</u> NAME OF CEMETERY OR CREMATORY <u>Prospect</u> LOCATION (City, town, or county) (State) <u>Frederick Co., Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>13 Dec 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heeb</u> 24. FUNERAL DIRECTOR ADDRESS <u>C. M. Waltz, Winfield, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 16 1955

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## 11968 CERTIFICATE OF DEATH

Reg. Dist. No. 141

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <b>Rural Knoxville</b>	<b>30 yrs.</b>	TOWN <b>Rural Knoxville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (if rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <b>Howard</b>	(Middle) <b>Marvin</b>	(Last) <b>Jones</b>	(Month) <b>12</b> (Day) <b>21</b> (Year) <b>1955</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <b>Widowed</b>	8. DATE OF BIRTH <b>5-21-1874</b>
9. AGE last birthday <b>81</b> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real estate, Ins.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Leouis R. Jones</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANDERSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <b>Alfred Jones, Falls Church, Va.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
260X IMMEDIATE CAUSE (A) <b>Cerebral Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized Arteriosclerosis</b>		<b>10 yrs</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Diabetes Semibity</b>		<b>15 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1954, to 12/21, 1955, that I last saw the deceased alive on 12/20, 1955, and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE <b>C. L. Brice</b>		ADDRESS (Street, city, town, state) <b>Jefferson</b>	
DATE SIGNED <b>12/23/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-24-55</b>	
NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		LOCATION (City, town, or county) <b>Brunswick, Maryland</b>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <b>Eugenia H. Bucke</b>		ADDRESS <b>C.H. Feete and Bro. Brunswick, Md</b>	
DATE <b>1-3-56</b>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# 1968 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH	12-21-68	PLACE OF DEATH	Home
DECEASED'S NAME	John Doe	DECEASED'S SEX	Male
DECEASED'S AGE	65	DECEASED'S RACE	White
DECEASED'S BIRTH DATE	06-15-03	DECEASED'S BIRTH PLACE	MD

DECEASED'S OCCUPATION	Teacher	DECEASED'S MARITAL STATUS	Married
DECEASED'S EDUCATION	High School	DECEASED'S RELIGION	Catholic
DECEASED'S SOCIAL SECURITY NO.	123-45-6789	DECEASED'S MOTHER'S MARRIAGE DATE	01-15-45
DECEASED'S MOTHER'S BIRTH DATE	03-20-15	DECEASED'S MOTHER'S BIRTH PLACE	MD

DECEASED'S FATHER'S BIRTH DATE	08-10-18	DECEASED'S FATHER'S BIRTH PLACE	MD
DECEASED'S FATHER'S OCCUPATION	Farmer	DECEASED'S FATHER'S MARITAL STATUS	Married
DECEASED'S FATHER'S EDUCATION	High School	DECEASED'S FATHER'S RELIGION	Catholic
DECEASED'S FATHER'S SOCIAL SECURITY NO.	987-65-4321	DECEASED'S FATHER'S MOTHER'S BIRTH DATE	05-05-12

DECEASED'S FATHER'S OCCUPATION	Teacher	DECEASED'S FATHER'S MARITAL STATUS	Married
DECEASED'S FATHER'S EDUCATION	High School	DECEASED'S FATHER'S RELIGION	Catholic
DECEASED'S FATHER'S SOCIAL SECURITY NO.	123-45-6789	DECEASED'S FATHER'S MOTHER'S BIRTH DATE	03-10-10
DECEASED'S FATHER'S MOTHER'S BIRTH PLACE	MD	DECEASED'S FATHER'S MOTHER'S OCCUPATION	Homemaker

DECEASED'S FATHER'S OCCUPATION	Teacher	DECEASED'S FATHER'S MARITAL STATUS	Married
DECEASED'S FATHER'S EDUCATION	High School	DECEASED'S FATHER'S RELIGION	Catholic
DECEASED'S FATHER'S SOCIAL SECURITY NO.	123-45-6789	DECEASED'S FATHER'S MOTHER'S BIRTH DATE	03-10-10
DECEASED'S FATHER'S MOTHER'S BIRTH PLACE	MD	DECEASED'S FATHER'S MOTHER'S OCCUPATION	Homemaker

DECEASED'S FATHER'S OCCUPATION	Teacher	DECEASED'S FATHER'S MARITAL STATUS	Married
DECEASED'S FATHER'S EDUCATION	High School	DECEASED'S FATHER'S RELIGION	Catholic
DECEASED'S FATHER'S SOCIAL SECURITY NO.	123-45-6789	DECEASED'S FATHER'S MOTHER'S BIRTH DATE	03-10-10
DECEASED'S FATHER'S MOTHER'S BIRTH PLACE	MD	DECEASED'S FATHER'S MOTHER'S OCCUPATION	Homemaker

BUREAU V. E.

JAN 5 1956

RECEIVED

11969

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Prince Georges</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Cullen</b>		926 days.		OR TOWN <b>Laurel</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>				STREET ADDRESS (If rural give location) <b>Washington Boulevard</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>Luther E. Leanhart</b>				<b>December 23, 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Oct. 4, 1899</b>	<b>56</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Truck driver</b>			<b>Truck Driver</b>	<b>Maryland.</b>		<b>U. S. A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Eugene Leanhart</b>				<b>Laura Studebaker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>No</b>				<b>?</b>		<b>Luther E. Leanhart, Laurel, Maryland.</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Pulmonary Tuberculosis</b>							<b>3 years.</b>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 10, 1953</b> , to <b>Dec. 23, 1955</b> that I last saw the deceased alive on <b>Dec. 23, 1955</b> , and that death occurred at <b>7:40 p.m.</b> M, from the causes and on the date stated above.							
SIGNATURE		<b>M. D. Cullen, Maryland</b>		DATE SIGNED <b>December 27, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Removal</b>		<b>12-29-55</b>		<b>Anatomy Board, U. of Md. Medical School</b>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>12/27/55</b>		<b>M. L. Creager &amp; Son, Thurmont, Md.</b>					

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 30 1955

BUREAU V. S.

11970

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>FREDERICK</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>FREDERICK</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>X TOWN YELLOW SPRINGS</b>		LENGTH OF STAY (in this place) <b>Lifelong</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>X TOWN Yellow Springs</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>RURAL,</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>ANNIE MAY MARTZ</b>				4. DATE OF DEATH: Dec. 5 19 55			
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE MARRIED WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH: <b>Aug. 6, 1870</b>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>Home Making</b>		9. AGE last birthday: <b>85</b> yrs. <b>3</b> Months <b>29</b> Days <b></b> Hours <b></b> Min.	
11. BIRTHPLACE (State or foreign country): <b>Frederick, County, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME: <b>Jacob Zimmerman</b>				14. MOTHER'S MAIDEN NAME: <b>Ann Rebecca Ramsburg</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>None</b>		17. INFORMANT & ADDRESS: <b>Son, Louis J. Martz, Yellow Springs Md.</b>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <b>420.0 Congestive Heart failure</b>						<b>1 day</b>	
Antecedent causes (s) (b) <b>Arterio Sclerotic Heart Disease</b>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <b>0</b>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12-5-1955</b> to <b>12-5-1955</b> , that I last saw the deceased alive on <b>12-5-1955</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>A. Fisher</b>				DATE SIGNED <b>6 Dec 1955</b>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>12-7-55</b>		<b>Mt. Olivet</b>		<b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6 Dec 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth G. Hebb</b>		24. FUNERAL DIRECTOR <b>Robert E. Dailey</b>		ADDRESS <b>FREDERICK, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11955

11941

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN Frederick</u>		LENGTH OF STAY (in this place) <u>Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>507 Lee Place</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>AUSTIN HENRY McDEVITT</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 25, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 26, 1903</u>	9. AGE last birthday <u>52</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Everedy Company</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles McDevitt</u>				14. MOTHER'S MAIDEN NAME <u>Nora Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-3616</u>		17. INFORMANT & ADDRESS <u>507 Lee Place, Mrs. Grace C. McDevitt, Frederick, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
584X IMMEDIATE CAUSE (A) <u>Acute hemorrhagic pancreatitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Gall stones</u>						<u>unk</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 10</u> , 19 <u>55</u> , to <u>Dec 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>55</u> , and that death occurred at <u>5:00P</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>H. H. Kline</u>		M.D. <u>Frederick, Maryland</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12/28/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
24. REC'D BY REGISTRAR <u>28 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heik</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

Ans. H. of the 1st 13

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11942

## CERTIFICATE OF DEATH

11956

Reg. Dist. No. 131

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	LENGTH OF STAY (In this place) <i>4 yrs.</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Frederick Mem. Hospital</i>		STREET ADDRESS (If rural give location) <i>103 E. 6th. St.</i>	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>VIRGINIA</i> (First) (Middle) (Last) <i>Mc MILLAN</i>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>DEC. 28 19 55</i>	
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>1-16-1907</i>
<b>9. AGE last birthday</b> <i>48</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Own Home</i>	<b>11. BIRTHPLACE</b> (State or foreign country) <i>Illinois</i>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>			
<b>13. FATHER'S NAME</b> <i>Robert W. Meredith</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Nannie A. Rose</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>227-05-9069</i>	<b>17. INFORMANT &amp; ADDRESS</b> <i>R 70-Union Bridge-rd Mrs. Meredith Mercer (daughter)</i>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			<b>18. MEDICAL CERTIFICATION</b>
<b>420.1 IMMEDIATE CAUSE</b> (A) <i>Congestive Failure</i>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>6 Mos</i>
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <i>Large Anterior Myocardial infarction</i>			<i>? years</i>
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <i>of unknown etiology</i>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Auricular Fibrillation (+ Vent. fib. (?)</i>			<i>2 Mos</i>
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>	<b>21f. HOW DID INJURY OCCUR?</b>
<b>22. I hereby certify that I attended the deceased from 19 51 to 12/28, 19 55, that I last saw the deceased alive on 12/28, 19 55, and that death occurred at 5:45 P.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>Charles H. Corley</i>		<b>ADDRESS (Street, city, town, state)</b> <i>Frederick, Maryland</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE SIGNED</b> <i>12/28/55</i>	
<b>DATE THEREOF</b> <i>12-31-55</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Hytheville - Va.</i>	
<b>24. REC'D BY REGISTRAR</b> <i>Elizabeth G. Heck</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>C.E. Cloutson</i>	
<b>DATE</b> <i>29 Dec. 1955</i>		<b>ADDRESS</b> <i>Frederick - Md.</i>	

# CERTIFICATE OF DEATH

1. DEATH CERTIFICATE NUMBER

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. TIME OF BIRTH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. PLACE OF BIRTH

12. DATE OF BIRTH

13. TIME OF BIRTH

14. PLACE OF DEATH

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF BIRTH

18. DATE OF BIRTH

19. TIME OF BIRTH

20. PLACE OF DEATH

21. DATE OF DEATH

22. TIME OF DEATH

23. PLACE OF BIRTH

24. DATE OF BIRTH

25. TIME OF BIRTH

26. PLACE OF DEATH

27. DATE OF DEATH

28. TIME OF DEATH

BUREAU V. S.

JAN 2 1956

RECEIVED

1956-1957

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11943

## CERTIFICATE OF DEATH

11957

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Frederick</u>		<u>44</u> Yrs.		TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>300 Park Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>BENJAMIN</u> (Middle) <u>FRANKLIN</u> (Last) <u>MILLER</u>				<u>December 4, 19 55</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>White</u>		<u>Widowed</u>		<u>9 Nov 1872</u>	
<b>9. AGE last birthday</b>		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>			
<u>83</u> yrs.		Months Days		Hours Min.			
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>	
<u>Retired Deliveryman</u>				<u>Dairy</u>		<u>Maryland</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>James A. Miller</u>				<u>Lucretia Longman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>				<u>None</u>		<u>300 Park Ave., Miss Esther V. Miller, Frederick, Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis - arteriosclerotic heart disease</u>						<u>4 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>none</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>0</u>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>12/4/ 19 55</u>		<u>2:40P</u>					
<b>22. I hereby certify that I attended the deceased from <u>6/1/ 19 55</u>, to <u>12/4/ 19 55</u>, that I last saw the deceased alive on <u>12/4/ 19 55</u>, and that death occurred at <u>2:40P</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>A. A. Pearce</u> M.D.				<b>DATE SIGNED</b> <u>5 Dec 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>7 Dec 1955</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>DEC 7 1955</u>		<u>Elizabeth G. Juck</u>		<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			



# CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		PLACE OF BIRTH	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF WITNESSES		NAME OF REGISTRAR	

BUREAU V. S.

DEC 7 1955

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No. 131

11971

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Mt. Pleasant	LENGTH OF STAY (in this place) 2 months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) 210 South Carroll Street	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Joshua	(Middle) Eli	(Last) Murphy	(Month) 14 (Day) 19 (Year) 55
5. SEX: Male		6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 15-1859		9. AGE last birthday: 66 yrs.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Brakeman		10b. KIND OF BUSINESS OR INDUSTRY: Electric Railway	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: William Elias Murphy	
14. MOTHER'S MAIDEN NAME: Mary Phelps		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	
16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Mrs. Edward L. Cramer-Rt. 1-Mt. Pleasant-Md.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) Pulmonary Metastases of Carcinoma			11 months
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma of Larynx			8 1/2 years
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 1, 1947, to Dec. 14, 1955, that I last saw the deceased alive on Dec. 14, 1955, and that death occurred at 6:10 P.M., from the causes and on the date stated above.			
SIGNATURE S. R. Schoorman M.D.		ADDRESS Frederick Md. 12-16-55	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	12-17-1955	Mt. Olivet Cemetery	Frederick-Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
16 Dec. 1955	Elizabeth G. Hech	C. E. Cline & Son Frederick-Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 19 1955

BUREAU V. S.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE: [illegible]

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE SUPREME COURT, COUNTY OF [illegible], STATE OF NEW YORK, AND IN THE OFFICE OF THE CLERK OF THE COUNTY CLERK, COUNTY OF [illegible], STATE OF NEW YORK.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 18 Film G190-12-20-55 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11959

11944 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>		LENGTH OF STAY (in this place) <u>22 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Detour Rural 06x-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Memorial</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Ernest D. Myers</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12 10 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>3/5/1915</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country): <u>Carroll Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Rufus Myers</u>				14. MOTHER'S MAIDEN NAME: <u>Mary C. Gouker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS: <u>Mrs Bessie Myers</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X IMMEDIATE CAUSE (A) <u>Adenocarcinoma of the body of the pancreas</u>							1 yr.
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/17</u> , 19 <u>55</u> , to <u>12/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>55</u> , and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Henry V. Chase</u>				ADDRESS <u>M. D. 4 E. Church St. Fred.</u>		DATE SIGNED <u>12/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Keysville Cem.</u>		LOCATION (City, town, or county) (State) <u>Keysville Carroll Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Hack</u>		24. FUNERAL DIRECTOR <u>M. L. Creager &amp; Son. Thurmont MD</u>		ADDRESS	

RECEIVED

DEC 13 1955

BUREAU V. S.

11972

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore City</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Cullen</b>		LENGTH OF STAY (in this place) <b>172 days.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>				STREET ADDRESS (If rural give location) <b>1634 Aliceanne Street,</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Roland Francis Nelson</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>December 9, 1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widower</b>	8. DATE OF BIRTH: <b>December 1, 1900</b>	9. AGE last birthday <b>55</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Seaman</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Seaman</b>		11. BIRTHPLACE (State or foreign country): <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>George Nelson</b>				14. MOTHER'S MAIDEN NAME: <b>Celia Reed</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <b>090-14-2871</b>		17. INFORMANT & ADDRESS: <b>Roland F. Nelson, 1634 Aliceanne St., Balto. Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Pulmonary Tuberculosis.</b>						10 months.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 20, 1955</b> , to <b>Dec. 9, 1955</b> , that I last saw the deceased alive on <b>Dec. 9, 1955</b> , and that death occurred at <b>11:00</b> M., from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		M.D. <b>Cullen, Maryland</b>		DATE SIGNED <b>December 10, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-12-55</b>		NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>12/10/55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>DeWitt Donaldson, Laurel, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINNING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 13 1955

BUREAU V. S.



11973

## CERTIFICATE OF DEATH

Reg. Dist. No. 138

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Rural - Mt. Airy</i>	<i>13 years</i>	TOWN <i>Rural - Mt. Airy</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<i>Route 1 - (Bartholows)</i>		<i>Route 1 - (Bartholows)</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Abram Garfield Poole</i>		DEATH: <i>December 7 1955</i>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>May 29, 1882</i>
9. AGE last birthday		10. DATE OF BIRTH:	
<i>73 yrs.</i>		<i>73 yrs.</i>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<i>William Washington Poole</i>		<i>Eliza Virginia Hall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No.</i>		<i>219-20-0336</i>	
17. INFORMANT & ADDRESS:			
<i>Mrs. Abram G. Poole - Rt. 1 - Mt. Airy.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<i>420.0</i>		
IMMEDIATE CAUSE (A)		<i>21 hours</i>
DUE TO <i>Coronary Thrombosis</i>		
ANTECEDENT CAUSE (S)		
DUE TO <i>Arteriosclerotic Heart Disease</i>		<i>several years.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>0</i>		

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *May*, 1950, to *December*, 1955, that I last saw the deceased alive on *December 6, 1955*, and that death occurred at *159* A.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS	DATE SIGNED
<i>W.B. Culwell</i>	<i>Mt. Airy, Md.</i>	<i>December 7, 1955</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>Dec. 9, 1955</i>	<i>Pleasant Hill</i>
LOCATION (City, town, or county) (State)		
<i>Monrovia, Fred. Co. Md.</i>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR
<i>Dec 5 - 1955</i>	<i>Lucas K. Falconer</i>	<i>Olin L. Moleworth, Damascus, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 15 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11962

## 11945 CERTIFICATE OF DEATH

Reg. Dist. No. 144

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>Several minutes</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lewistown, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u></u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Charles Clayton Putman</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 19, 1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>October 31, 1881</u>	<b>9. AGE last birthday</b> <u>74</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gen Contractor</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Creagerstown, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Greenberry Putman</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Joy Putman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>215-18-6849</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Bessie Mort Putman Lewistown, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>422.1 IMMEDIATE CAUSE (A)</b> <u>myocardial failure</u>						<u>6 hrs.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Chronic myocarditis</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)</b> <u>Arteriosclerosis</u>						<u>?</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Dec. 2, 1955</u> , to <u>Dec. 19, 1955</u> , that I last saw the deceased alive on <u>Dec. 18, 1955</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>M. Franklin Bink</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Thurmont Md.</u>		<b>DATE SIGNED</b> <u>12/20/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12/21/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>United Brethern Cem.</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Thurmont, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Blanche S. Eyles</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>M.L. Creager and Son</u>		<b>ADDRESS</b> <u>Thurmont, Md.</u>	

2017-2018

9. *Hydrolysis*

*Indigofera tinctoria*

5. 1998/11/20 17:05 03

BUREAU V. S.

DEC 23 1955

RECEIVED

B

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

11963

Reg. Dist. No. 131

11946

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FREDERICK</u>		<u>2 yrs.</u>		TOWN <u>FREDERICK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FREDERICK MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>346 PARK AVE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>A</u> (Last) <u>REID</u>				(Month) <u>DEC</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>8-25-53</u>		9. AGE last birthday <u>2</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES R. REID</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE PINNEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mother.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>5 days.</u>	
491x IMMEDIATE CAUSE (A) <u>BRONCHOPNEUMONIA</u>							
DUE TO ANTECEDENT CAUSE(S) (B) <u>MUCOVISCIDOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12-12</u> , 19 <u>55</u> , to <u>12-19</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>12-19</u> , 19 <u>55</u> , and that death occurred at <u>5:20</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Frederick H. Heck</u> M.D.				ADDRESS (Street, city, town, state) <u>220 N. Market St. Frederick Md.</u>		DATE SIGNED <u>12-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Elizabeth H. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Bailey</u>		ADDRESS <u>FREDERICK, MD.</u>	
DATE <u>20 Dec. 1955</u>							

# CERTIFICATE OF DEATH

Official use only - to be filled in by the registrar

10

BUREAU V. S.

DEC 21 1955

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the registrar of the local health department or by the physician in attendance at the death. It is to be filled out in the case of all deaths, whether or not the death is due to natural causes, and whether or not the death is reported to the health department. It is to be filled out in the case of all deaths, whether or not the death is due to natural causes, and whether or not the death is reported to the health department. It is to be filled out in the case of all deaths, whether or not the death is due to natural causes, and whether or not the death is reported to the health department.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

11964

# 11974 CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Adamstown-Rural-R.D.#1</u> LENGTH OF STAY (In this place) <u>Years</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Adamstown-Rural-R.D.#1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Buckeystown</u>				STREET ADDRESS (If rural, give location) <u>Near Buckeystown</u>			
3. NAME OF DECEASED (First) <u>NETTIE</u>		(Middle) <u>LEOTA</u>		(Last) <u>REMSBERG</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 12, 1927</u>	
9. AGE last birthday <u>28</u> yrs.		If under 1 year Months <u>  </u> Days <u>  </u>		If under 24 hrs. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Kolb</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Ramsburg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mr. Willis D. Remsburg, Adamstown, R.D.#1, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) <u>Gun Shot wound of chest</u>							
(b) <u>Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
(c) <u>penetrated thru heart</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>Dec 25 1955</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		(CITY OR TOWN) <u>Near Buckeystown Frederick</u> (COUNTY) <u>Md</u> (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec. 25 1955 3:30 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR <u>Gun Shot wound Self inflicted</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <u>R. P. Phelan</u>				DEGREE OR TITLE <u>Deputy Medical Examiner, Frederick, Maryland</u>			
DATE SIGNED <u>12/28/1955</u>							
23. BURIAL, CREMATION OR OTHER (Specify) <u>Burial</u>		DATE THEREOF <u>Dec. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Greagerstown, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>27 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Heck</u>		24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

BUREAU V. 4

DEC 28 1955

RECEIVED

11975

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>Frederick - Rural</u>	<u>2 days</u>	<u>Beaver Bridge Rural</u>	
HOSPITAL OR INSTITUTION, OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>Frederick County Chronic Hospital</u>		<u>Johnsville</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		DATE OF DEATH:	
<u>FANNIE BELLE</u>	<u>REPP</u>	<u>Dec. 19</u>	<u>1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>July 3 - 1892</u>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
<u>83 yrs.</u>	<u>seamstress</u>		
11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?		
<u>Maryland</u>	<u>U. S.</u>		
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>William Repp</u>		<u>Catherine Herx</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>215-18-1792</u>	
17. INFORMANT & ADDRESS:			
<u>Hospital records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>			<u>3 days</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerotic VD</u>			<u>10 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive VD</u>			<u>30 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April, 1950</u> , to <u>19 Dec., 1955</u> , that I last saw the deceased alive on <u>19 Dec., 1955</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>James E. Homan, Jr.</u>		<u>19 Dec 55</u>	
M. D.		ADDRESS	
		<u>Waldersville, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>12/21/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Beaver Dam Cem.</u>		<u>Frederick County, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Dec 20/55</u>		<u>Elizabeth S. Heck</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>O. D. Hartley &amp; Sons</u>		<u>Beaver Bridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 22 1955

BUREAU V. S.

11947

## CERTIFICATE OF DEATH

Reg. Dist. No. 11966

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>FREDERICK</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>FREDERICK</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN FREDERICK</u>	LENGTH OF STAY (in this place) <u>0 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN FREDERICK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 FREDERICK MEM. HOSP.</u>		STREET ADDRESS (If rural give location) <u>309 MADISON ST.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>TINA</u>	(Middle) <u>FRANCES</u>	(Last) <u>RIVRERA</u>	
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>NEGRO</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>12-12-55</u>	
9. AGE last birthday		10. AGE last birthday	
yrs. <u>8</u>		yrs. <u>8</u>	
11. MONTHS <u>8</u>		12. DAYS <u>8</u>	
13. HOURS <u>8</u>		14. MIN. <u>8</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		<u>MD.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MD.</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>ROLAND FOREMAN</u>		<u>FAY INEZ RIVRERA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>9</u>		<u>—</u>	
17. INFORMANT & ADDRESS:			
<u>Mother</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
774X			
IMMEDIATE CAUSE (A) <u>GASTO-INTESTINAL HEIMORRAGE</u>			
ANTECEDENT CAUSE (S) DUE TO			
(B) <u>HYPO PROTHROMBINEMIA</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>PREMATURITY</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-12</u> , 19 <u>55</u> , to <u>12-20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-20</u> , 19 <u>55</u> , and that death occurred at <u>5:35</u> P.M., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Theresa H. H. H.</u>		<u>12-20-55</u>	
M. D. <u>220 N. MARKET ST.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>BURIAL</u>		<u>12-22-55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>FAIRVIEW</u>		<u>FREDERICK - MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>22 Dec. 1955</u>		<u>Chas. E. Hicks III</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Elizabeth L. Heck</u>		<u>Fred. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 27 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

11967

131

Reg. Dist. No. ....

11948

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN FREDERICK</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 TOWN FREDERICK</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 FREDERICK MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>463 West South Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>BABY BOY SHANK</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>DEC. 23 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12-23-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PAUL SHANK</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET STONEBURNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
7735 IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>FETAL IMMATURITY</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>12-23</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-23</u> , 19 <u>55</u> , to <u>12-23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-23</u> , 19 <u>55</u> , and that death occurred at <u>5:20 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Dr. Fredrick P. ...</u>				ADDRESS (Street, city, town, state) <u>220 N. Market</u>			
DATE SIGNED <u>12-23-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>27 Dec 1955</u>		LOCATION (City, town, or county) (State) <u>Mount Olivet Cemetery Frederick, Maryland</u>			
24. REC'D BY REGISTRAR DATE <u>27 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth L. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Md.</u>		ADDRESS	



11968

11976

## CERTIFICATE OF DEATH

Reg. Dist. No. 145-

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Rural Myersville		3 yrs		X TOWN Rural Myersville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Route #2				Route #2			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
JERRY EUGENE SMITH				Dec. 25 1955			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		white		single		March 5, 1952	
9. AGE last birthday:		10. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
3 yrs.		none		Frederick, Md.		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Raymond Smith				Mary Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
4 no		none		Raymond Smith, Myersville, Md. Rt. #2			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
351X Immediate cause						Sudden	
(a) DUE TO Congenital Heart Disease							
(b) DUE TO (Cerebral Palsy)							
(c) DUE TO							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED		HOW DID INJURY OCCUR?			
		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Birth, 1952, to Dec 25, 1955, that I last saw the deceased alive on Dec 3, 1955, and that death occurred at 2:00 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
J. J. Hays, M.D.				700 S. Main St.		12-26-55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Dec. 27, 1955		United Brethren		Pleasant Walk, Fred. Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Dec. 27, 1955		Floyd M. Bittle		Paul F. Bittle, Myersville, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 29 1955

RECEIVED

11949

## CERTIFICATE OF DEATH

11969  
Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>Frederick, RFD #6</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Randall Earl Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 3 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>—</u>	8. DATE OF BIRTH: <u>November 30, 1955</u>	9. AGE last birthday: If UNDER 1 YEAR If UNDER 24 HRS. <u>6</u> yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>—</u>		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>—</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Infant</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Watson Earl Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Stella Mae Wolfe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Stella Mae Smith Frederick RFD 6</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
<u>773.5</u> Immediate cause (a) <u>Prematurity</u> Antecedent cause(s) (b) <u>Sclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		<u>1 day</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11-30, 1955</u> to <u>12-3, 1955</u> , that I last saw the deceased alive on <u>11-3, 1955</u> and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. Frederick J. Heldrich, Jr.</u>		DATE SIGNED <u>12-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>5 Dec 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>
LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5 Dec 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

20X5202350

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: write the causes of death clearly and legibly.

BUREAU V. S.

DEC 6 1955

RECEIVED



**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

11977 **CERTIFICATE OF DEATH**

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Frederick-Rural-R.D.#5</u>		<u>Years</u>		TOWN <u>Frederick-Rural-R.D.#5</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Braddock Heights</u>				STREET ADDRESS (If rural give location) <u>Near Braddock Heights</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>EDWARD</u> (Middle) <u>J. A.</u> (Last) <u>STROBEK</u>				(Month) <u>December</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>June 7, 1878</u>	<u>77</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired Pharmist		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-1673</u>		17. INFORMANT & ADDRESS <u>Mrs. Russell H. Yinger, Frederick, R.D.#5</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.0 IMMEDIATE CAUSE (A) <u>Rupture Right Adrenal Gland</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>generalized arteriosclerosis</u>						<u>5 years</u>	
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 Da</u> , 19 <u>54</u> , to <u>24 Da</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 Da</u> , 19 <u>55</u> , and that death occurred at <u>10:14 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas L. Stone</u>				ADDRESS (Street, city, town, state) <u>445 3rd St</u>		DATE SIGNED <u>25 Da 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>27 Dec. 1955</u>				<u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

CERTIFICATE OF DEATH

Form 100-100-100

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Nature of disease		8. Duration of disease		9. Date of onset		10. Date of admission to hospital	
11. Name of physician		12. Name of hospital		13. Name of attending physician		14. Name of pathologist		15. Name of coroner	
16. Name of registrar		17. Name of funeral director		18. Name of cemetery		19. Name of place of burial		20. Name of place of interment	
21. Name of place of death		22. Name of place of death		23. Name of place of death		24. Name of place of death		25. Name of place of death	
26. Name of place of death		27. Name of place of death		28. Name of place of death		29. Name of place of death		30. Name of place of death	
31. Name of place of death		32. Name of place of death		33. Name of place of death		34. Name of place of death		35. Name of place of death	
36. Name of place of death		37. Name of place of death		38. Name of place of death		39. Name of place of death		40. Name of place of death	
41. Name of place of death		42. Name of place of death		43. Name of place of death		44. Name of place of death		45. Name of place of death	
46. Name of place of death		47. Name of place of death		48. Name of place of death		49. Name of place of death		50. Name of place of death	
51. Name of place of death		52. Name of place of death		53. Name of place of death		54. Name of place of death		55. Name of place of death	
56. Name of place of death		57. Name of place of death		58. Name of place of death		59. Name of place of death		60. Name of place of death	
61. Name of place of death		62. Name of place of death		63. Name of place of death		64. Name of place of death		65. Name of place of death	
66. Name of place of death		67. Name of place of death		68. Name of place of death		69. Name of place of death		70. Name of place of death	
71. Name of place of death		72. Name of place of death		73. Name of place of death		74. Name of place of death		75. Name of place of death	
76. Name of place of death		77. Name of place of death		78. Name of place of death		79. Name of place of death		80. Name of place of death	
81. Name of place of death		82. Name of place of death		83. Name of place of death		84. Name of place of death		85. Name of place of death	
86. Name of place of death		87. Name of place of death		88. Name of place of death		89. Name of place of death		90. Name of place of death	
91. Name of place of death		92. Name of place of death		93. Name of place of death		94. Name of place of death		95. Name of place of death	
96. Name of place of death		97. Name of place of death		98. Name of place of death		99. Name of place of death		100. Name of place of death	

BUREAU V. E.

DEC 28 1955

RECEIVED

Handwritten signature and date

NOTIFICATION  
The undersigned hereby certifies that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, on the 28th day of December, 1955.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11971

11950

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Frederick</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Frederick</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
11 <i>Frederick</i>		<i>1 week</i>		<i>Rural Middletown</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Fred. Memorial Hosp.</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>CHARLES A. SUMMERS</i>				<i>12 22 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>male</i>	<i>white</i>	<i>married</i>	<i>4-19-1885</i>	<i>70</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>carpenter</i>		<i>construction</i>		<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Martin L. Summers</i>				<i>Catherine Poffinberger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>				<i>Mrs. Marinda Summers, Middletown, Md.</i>			
<b>18. MEDICAL CERTIFICATION</b>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1 IMMEDIATE CAUSE (A) <i>Uremia</i>						<i>3 days</i>	
2 ANTECEDENT CAUSE(S) DUE TO <i>Chronic pyelonephritis</i>							
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1953</i> , to <i>22 December 1955</i> , that I last saw the deceased alive on <i>22 December, 1955</i> , and that death occurred at <i>8:10 P.</i> M. from the causes and on the date stated above.							
SIGNATURE <i>James B. Thompson</i>				ADDRESS <i>220 N. Market St. Frederick, Md.</i>		DATE SIGNED <i>12/24/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Burial</i>		<i>12-26-55</i>		<i>Church Hill Cem.</i>		<i>Frederick Co. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>26 Dec 1955</i>		<i>Elizabeth B. Heick</i>		<i>Gladhill Co., Middletown, Md.</i>			

REPORT OF DEATH

1955

LOCAL HEALTH DEPARTMENT AND CLERK

MARYLAND

CHARLES A. SUMMERS

4-19-1932

Carroll County, Maryland

Martin & Summers

Carroll County, Maryland

BUREAU V. S.

DEC 29 1955

RECEIVED

Summers 12-22-55

12-22-55

11951

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY *Frederick*

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) *Frederick*

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

*Frederick Memorial Hospital*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *Maryland* COUNTY *Frederick*CITY (If outside corporate limits, write RURAL and give nearest town) OR *Frederick*

STREET ADDRESS

(If rural give location)

*125 East Patrick Street*

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

*Wayne Edward Thompson*

4. DATE (Month)

(Day)

(Year)

OF

DEATH: *December 10 19 55*

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

*Male**white**—**December 9 1955*

yrs.

Months

Days

Hours

Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

*Infant*

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

*Maryland*

## 12. CITIZEN OF WHAT COUNTRY?

*USA*

## 13. FATHER'S NAME:

*Donald Edward Fritz*

## 14. MOTHER'S MAIDEN NAME:

*Catherine Elizabeth Miller*

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)

*No*

## 16. SOCIAL SECURITY NO.

*None*

## 17. INFORMANT &amp; ADDRESS:

*Mrs. Catherine Thompson Frederick, Md.*

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## IMMEDIATE CAUSE

## ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(A)

DUE TO

(B)

DUE TO

(C)

## INTERVAL BETWEEN ONSET AND DEATH

*18 hrs**?**?*

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☒NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

## 21E. INJURY OCCURRED

While ☐Not while ☐at work ☐at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *9 am*, 19*55*, to *10 am*, 19*55*, that I last saw the deceasedalive on *10 Dec 55*, 19*55*, and that death occurred at *6:25 PM*, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

*H. M. Power Jr*

M. D.

*Frederick, Md**10 Dec 55*

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

*Burial**12 Dec 1955**Mount Olivet Cemetery**Frederick, Maryland*

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

*12 Dec. 1955**Elizabeth S. Hark**M. R. Etchison & Son, Frederick, Maryland*

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 13 1955

BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11973

11952 **CERTIFICATE OF DEATH**

Reg. Dist. No. 131

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Frederick</b>		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>30 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>		STREET ADDRESS (If rural give location) <b>711 Motter Avenue</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>BARBARA ANN TRUMP</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>December 12, 1955</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widow</b>	<b>8. DATE OF BIRTH</b> <b>31 May 1870</b>	<b>9. AGE last birthday</b> <b>85</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House-work</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>At Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Daniel Smith</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Kenney</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>711 Motter Ave., Mrs. Lewis F. Esterly, Frederick, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>260X IMMEDIATE CAUSE (A)</b>				<b>Diabetes Mellitus</b>		<b>10 yrs.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<b>Arterio Sclerosis</b>		<b>10 yrs.</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 19 40 to Dec 12 1955, that I last saw the deceased alive on Dec 12 1955, and that death occurred at 10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>H. F. Kline</i>				<b>ADDRESS</b> (Street, city, town, state) <b>Frederick, Maryland</b>		<b>DATE SIGNED</b> <b>13 Dec 1955</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>15 Dec 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Glade Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Walkersville, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Elizabeth S. Heck</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		<b>ADDRESS</b>	

1  
RECEIVED  
JAN 20 1955  
BUREAU OF HEALTH - BALTIMORE

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 68	
4. DATE OF DEATH Jan 18 1955		5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease	
7. SIGNATURE OF DECEASED (None)		8. SIGNATURE OF WITNESSES J. H. Harris		9. SIGNATURE OF PHYSICIAN J. H. Harris	
10. SIGNATURE OF REGISTRAR J. H. Harris		11. SIGNATURE OF CLERK J. H. Harris		12. SIGNATURE OF JURY J. H. Harris	

BUREAU V. 2

JAN 18 1955

RECEIVED

18 JAN 1955

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11974

11978 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....131.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Frederick-Rural-R.D.#3</u>		LENGTH OF STAY (In this place) <u>Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>Frederick-Rural-R.D.#3</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hansonville</u>				STREET ADDRESS (If rural give location) <u>Hansonville</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>GUSTA</u> (First) <u>SAMUEL</u> (Middle) <u>WACHTER</u> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>December 20,</u> 19 <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, <del>DIVORCED</del> (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>November 16, 1877</u>		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Philip Wachter</u>				14. MOTHER'S MAIDEN NAME <u>Marietta Fout</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. George S. Wachter, Frederick, R.D.#, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
581.0 IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronicity of liver</u>						<u>4 1/2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Myocarditis</u>						<u>4 1/2 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>May 13</u> 19 <u>30</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 13</u> , 19 <u>30</u> , to <u>Dec 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>55</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ed Thomas</u>				ADDRESS (Street, city, town, state) <u>Frederick, Maryland</u>		DATE SIGNED <u>12/21/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Reformed Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chralesville, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>21 Dec 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth B. Herb</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M.R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Form No. 101

REGISTRATION DISTRICT OF DEATH

DATE OF DEATH

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DATE OF DEATH

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BUREAU V. S.

DEC 22 1955

RECEIVED

NOTIFICATION

ADDITIONAL INFORMATION ON DEATH OF DECEASED

11979

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Frederick</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<i>Rural, Mr. Feagarville</i>	<i>20 yrs.</i>	<i>Rural, Mr. Feagarville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <i>WILLIAM</i>	(Middle) <i>WINTFIELD</i>	(Last) <i>West</i>	<i>Dec 4 1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Divorced</i>	8. DATE OF BIRTH: <i>Dec. 12 1882</i>
9. AGE last birthday: <i>72</i> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>	11. BIRTHPLACE (State or foreign country): <i>md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME: <i>John D. West</i>		14. MOTHER'S MAIDEN NAME: <i>Butler</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>If no</i>		17. INFORMANT & ADDRESS: <i>Mrs L. Monroe West, Fred. R 4. Md.</i>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.2 IMMEDIATE CAUSE		<i>21 days</i>	
ANTECEDENT CAUSE (S)		<i>10 days</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <i>Pulmonary Edema</i>			
(B) <i>Myocardial decompensation</i>			
(C) <i>with Chronic Passive Congestion</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<i>2 wks</i>	
19A. DATE OF OPERATION: <i>0</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11/16</i> , 1955, to <i>12/4</i> 1955, that I last saw the deceased alive on <i>12/3</i> , 1955, and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>A. G. Brice</i>		DATE SIGNED <i>12/5/55</i>	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/7/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Linganore</i>		LOCATION (City, town, or county) (State) <i>Unionville, md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6 Dec. 1955</i>		24. FUNERAL DIRECTOR ADDRESS <i>W.C. Barton, Walkersville, Md.</i>	
REGISTRAR'S SIGNATURE <i>Elizabeth G. Hede</i>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11976

11930

## CERTIFICATE OF DEATH

Reg. Dist. No. 140

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEW MIDWAY</u>		LENGTH OF STAY (In this place) <u>YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEW MIDWAY</u>		<u>RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>EZRA DAVID WETZEL</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>DEC 26 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>FEB 2-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TENANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY WETZEL</u>				14. MOTHER'S MAIDEN NAME <u>MARY NAILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>MRS EDGAR LAMBERT KEYMAR MD</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>myocardial failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerosis</u>				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 25, 19 55</u> , to <u>Dec. 26, 19 55</u> , that I last saw the deceased alive on <u>Dec. 25, 19 55</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. Franklin Bishy</u>				ADDRESS (Street, city, town, state) <u>Thurmond Ind.</u>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>LINGANORE</u>		LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
24. REC'D BY REGISTRAR DATE <u>DEC 30, 1955</u>		REGISTRAR'S SIGNATURE <u>L B Powell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>DD HARTZLER &amp; SONS</u>		ADDRESS <u>BRIDGE MD</u>	

# CERTIFICATE OF DEATH

REG. OFF. NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF DEPUTY CHIEF CLERK

24. SIGNATURE OF RECORDS CLERK

25. SIGNATURE OF CLERK OF THE COURT

26. SIGNATURE OF CLERK OF THE DISTRICT COURT

27. SIGNATURE OF CLERK OF THE COUNTY COURT

28. SIGNATURE OF CLERK OF THE JUDICIAL DEPARTMENT

29. SIGNATURE OF CLERK OF THE LEGISLATIVE DEPARTMENT

30. SIGNATURE OF CLERK OF THE EXECUTIVE DEPARTMENT

31. SIGNATURE OF CLERK OF THE FINANCIAL DEPARTMENT

32. SIGNATURE OF CLERK OF THE AGRICULTURAL DEPARTMENT

33. SIGNATURE OF CLERK OF THE COMMERCE DEPARTMENT

34. SIGNATURE OF CLERK OF THE EDUCATION DEPARTMENT

35. SIGNATURE OF CLERK OF THE HEALTH DEPARTMENT

36. SIGNATURE OF CLERK OF THE LABOR DEPARTMENT

37. SIGNATURE OF CLERK OF THE NATURAL RESOURCES DEPARTMENT

38. SIGNATURE OF CLERK OF THE TRANSPORTATION DEPARTMENT

39. SIGNATURE OF CLERK OF THE UTILITIES DEPARTMENT

40. SIGNATURE OF CLERK OF THE WELFARE DEPARTMENT

41. SIGNATURE OF CLERK OF THE ZONING DEPARTMENT

42. SIGNATURE OF CLERK OF THE PLANNING DEPARTMENT

43. SIGNATURE OF CLERK OF THE HISTORIC PRESERVATION DEPARTMENT

44. SIGNATURE OF CLERK OF THE PARKS AND RECREATION DEPARTMENT

45. SIGNATURE OF CLERK OF THE CULTURAL AFFAIRS DEPARTMENT

46. SIGNATURE OF CLERK OF THE RELIGION DEPARTMENT

47. SIGNATURE OF CLERK OF THE ARTS DEPARTMENT

48. SIGNATURE OF CLERK OF THE SCIENCE DEPARTMENT

49. SIGNATURE OF CLERK OF THE TECHNOLOGY DEPARTMENT

50. SIGNATURE OF CLERK OF THE SPACE DEPARTMENT

BUREAU V. S.

RECEIVED  
JAN 4 1956

NOTATION

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or jury, or by the clerk of the court, or by the clerk of the legislative department, or by the clerk of the executive department, or by the clerk of the financial department, or by the clerk of the agricultural department, or by the clerk of the commerce department, or by the clerk of the education department, or by the clerk of the health department, or by the clerk of the labor department, or by the clerk of the natural resources department, or by the clerk of the transportation department, or by the clerk of the utilities department, or by the clerk of the welfare department, or by the clerk of the zoning department, or by the clerk of the planning department, or by the clerk of the historic preservation department, or by the clerk of the parks and recreation department, or by the clerk of the cultural affairs department, or by the clerk of the religion department, or by the clerk of the arts department, or by the clerk of the science department, or by the clerk of the technology department, or by the clerk of the space department.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11981

## CERTIFICATE OF DEATH

11977

Reg. Dist. No. 131

1. PLACE OF DEATH: COUNTY <u>Frederick Co</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Frederick</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Frederick Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D.2</u>				STREET ADDRESS <u>R.D.2</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>CHARLES</u>		(Middle) <u>PATRICK</u>		(Last) <u>WILLIS</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>SEPT 10, 1875</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sharnoff Rubber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		9. AGE last birthday <u>80</u> yrs.		4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>20</u> (Year) <u>1955</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charles F. Willis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u></u>		17. INFORMANT <u>Henry L. Willis Frederick Co Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>156.1 Pulmonary Edema</u>						<u>1 Day</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Cerebral Edema of Liver</u>						<u>1 year</u>	
<u>Myocardial Infarction</u>						<u>1 week</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) <u>Indersburg Md</u>		(COUNTY) (STATE) <u>Frederick Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 20</u> , 19 <u>55</u> , to....., 19....., that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>55</u> , and that death occurred at <u>3 a</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Karl H. Lammertbaum</u>				ADDRESS <u></u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>Dec 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Yokelville Md</u>		LOCATION (City, town, or county) (State) <u>Montgomery Co Md</u>	
DATE REC'D BY LOCAL REG. <u>21 Dec, 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Hook</u>		24. FUNERAL DIRECTOR <u>Roy W. Barber</u>		ADDRESS <u>Yokelville Md</u>	

BUREAU V. S.

DEC 22 1955

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## MARYLAND STATE DEPARTMENT OF HEALTH

11978

2411 N. Charles Street, Baltimore

11932

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Fredenck</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fredenck - Rural</u>		MARYLAND LENGTH OF STAY (in this place) <u>80 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Fredenck</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fredenck</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kinda-bona Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>E. Patmuk St</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>ANN</u> (Middle) <u>SOPHIA</u> (Last) <u>WILSON</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>11/4/1875</u>	9. AGE last birthday <u>80</u> yrs.	If under 1 year If under 24 hrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Nathanial J Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ann Sophia Albough</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>4222</u>		17. INFORMANT <u>Mrs Paul Rhoades</u>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <u>Myocardial Decompensation</u>					
Antecedent cause(s) (b) <u>Senility</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 1</u> , 19 <u>55</u> , to <u>Dec 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>55</u> , and that death occurred at <u>6:20 P.</u> m., from the causes and on the date stated above.					
SIGNATURE <u>H. Lawrence Johnson MD</u>		ADDRESS <u>Fredenck Md</u>		DATE SIGNED <u>12-15-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>12/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	
LOCATION (City, town, or county) <u>Fredenck</u>		(State) <u>Md</u>			
DATE REC'D BY LOCAL REG. <u>15 Dec. 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR <u>Harry E. Gault</u>	
				ADDRESS <u>Fredenck Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 16 1955

BUREAU V. S.